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	IL6005938	A. BUILDING: _____ B. WING _____	C 02/25/2025

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LOFT REHAB OF DECATUR	500 WEST MCKINLEY AVENUE DECATUR, IL 62526

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S 000	Initial Comments Complaint Investigation 2560807/IL185423	S 000		
S9999	Final Observations Statement of Licensure Violations 300.310a) 300.1010h) 300.1210b) 300.1210d)4)A)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999		

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accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection,

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and prevent new pressure sores from developing.

These regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to implement resident centered interventions to prevent skin breakdown and worsening of pressure sores and failed to notify the wound physician and dietician of new open areas for one resident (R2) of three residents reviewed for pressure ulcers in a sample list of five residents. These failures resulted in R2 developing a stage four pressure area to R2's right ischium and unstageable pressure areas to R2's bilateral heels.

Findings Include:

The facility's policy Pressure Injury Prevention and Management reviewed 2/6/24 states "The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/injuries. The RN (Registered Nurse) Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document findings in the medical record. The attending physician will be notified of the presence of a new pressure injury upon identification, the progression towards healing or lack of healing, of any pressure injuries weekly. Any complications (such as infection, development of a sinus tract etc.) as needed."

The facility's policy Incontinence reviewed

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12/19/24 states: "Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services to ensure resident is maintained at highest functioning level related to continence of bowel and bladder and to assist in maintaining that level. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. Appropriate skin care will be maintained for those residents that are incontinent."

On 2/19/25 at 3:35PM R2's Ischium/Coccyx wound measured approximately four inches in diameter and three inches deep with malodorous yellow drainage. Muscle and bone were visible. Both heels had leathery black eschar approximately 2.5 inches in diameter.

R2's Admission Progress Note dated 12/18/24 at 3:00PM documents "Skin is intact; old bruising from fall that caused hospital admission."

R2's Physician's Order Summary printed 2/6/25 includes the following diagnoses: Obesity, History of Cerebral Infarction, Muscle Weakness, Generalized Anxiety Disorder, Major Depression, Paralytic Gait, and Reduced Mobility.

R2's Minimum Data Set (MDS) dated 12/25/24 documents R2 is cognitively intact, wheelchair dependent, dependent for transfer and toileting, and requires substantial/maximal assistance of staff for rolling in bed. This MDS also documents R2 is frequently incontinent of urine and bowel.

R2's standardized skin evaluation (Braden Scale) dated 12/30/24 at 1:15PM documents "Braden Evaluation: Moisture: Occasionally moist. Activity:

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Chairfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Adequate. Friction and shear: Potential problem."

R2's progress note dated 1/20/2025 at 2:58AM documents "CNA stated that she had found an open area on right buttock while changing resident and performing care to get ready for bedtime. Writer cleansed area with wound cleanser and applied (Medical Grade) honey and covered with border
gauze." There is no documentation a physician or family was notified.

There is no wound assessment documented until 1/23/25. The facility's Wound Weekly Observation Tool dated 1/23/25 identifies this wound as "number four." This wound assessment documents the wound measures 1.3 x 0.6 x 0.1 cm (centimeters). The section of the assessment concerning peri wound appearance is left blank on this assessment.

The January Treatment Administration Record (TAR) for January 2025 documents a treatment order change dated 1/24/25. The treatment orders: Cleanse right gluteal fold with wound cleanser. Pat dry. Apply (Medical Grade) honey then hydrocolloid every three days.

The next documented Wound weekly observation tool is dated 2/5/25. In this document the wound is renamed Right Ischium and measures 3.8 x 4.5 x 0 cm. This evaluation does not identify the wound as pressure wound and no stage is identified.

R2's Wound Evaluation and Management

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Summary dated 2/5/25 by V8 Wound Nurse Practitioner documents "a Stage IV pressure wound of greater than 10 days duration to R2's right ischium measuring 3.0 cm length by 3.6 cm width by 0.6 cm depth. This evaluation recommends a low air loss mattress.

R2's Wound Evaluation and Management Summary dated 2/19/25 by V8 Nurse Practitioner documents the Stage IV Pressure Ulcer to R2's right ischium now measures 8.0 x 5.0 x 4.5 cm.

R2's progress note dated 1/9/25 at 9:27PM documents "(R2) has blood blisters to both heels. Left heel wound measurement 1.2 cm X 1.5 cm. Right heel wound measurements 1.2 cm x 1.0. On 1/9/25 a physician's order was initiated per R2's January Treatment Administration Record (TAR) to Cleanse wounds with Normal Saline pat dry. Applied betadine to wound. Abdominal pad and wrapped with (rolled gauze) to both feet. Wound nurse notified of heels."

No treatment is documented on R2's Medication Administration Record (MAR) until 1/11/25. Treatment is ordered daily. R2's MAR does not document treatment as completed as ordered 1/13/25, 1/24/25, or 1/28/25.

R2's Initial Wound Evaluation and Management Summary dated 1/22/25 by V8 Nurse Practitioner documents an unstageable deep tissue pressure injury of greater than 14 days duration measuring 0.9 cm length by 2.2 cm width on R2's right heel and an unstageable deep tissue pressure injury of greater than 13 days duration measuring 3.8 cm length by 4.4 cm width on R2's left heel. There is no documentation to address R2's open area on the right gluteal fold. This evaluation recommends pressure relieving boots.

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R2's Wound Evaluation and Management Summary dated 1/29/25 by V8 Nurse Practitioner documents an unstageable deep tissue pressure injury of greater than 21 days duration on R2's right heel and an unstageable deep tissue pressure injury of greater than 20 days duration measuring 3.8 cm length by 4.5 cm width on R2's left heel. This evaluation recommends pressure relieving boots.

R2's Wound Evaluation and Management Summary dated 2/5/25 by V8 Nurse Practitioner documents an unstageable deep tissue pressure injury of greater than 28 days duration measuring 2.8 cm length by 2.5 cm width on R2's right heel and an unstageable deep tissue pressure injury of greater than 27 days duration measuring 3.8 cm length by 4.5 cm width on R2's left heel.

R2's Wound Evaluation and Management Summary dated 2/19/25 by V8 Nurse Practitioner documents the Stage IV Pressure Ulcer to R2's right ischium now measures 8.0 x 5.0 x 4.5 cm.

On 2/6/25 at 10:50AM R2 was seated in the therapy room in a bariatric wheelchair. At 11:30AM R2 was at the lunch table eating in the wheelchair. At 1:30PM R2 was sitting in R2's room in the wheelchair. R2 stated "I put on my call light and very often the aides come in and turn off the call light and then don't return to help me. I have bed sores and they don't change my (adult diaper). I (urinated) this morning in therapy and I have sat up in this chair since about 9:00AM without being changed. I'm afraid to complain because it might get worse. The wound doctor was pretty upset yesterday. I have these bed sores on my feet and the doctor has been seeing me for those, but I have one on my butt

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too and they didn't tell the doctor about that until yesterday." There were no pressure relieving boots in place during the above observations. R2 does not have a pressure relieving mattress in place to her bed. R2 stated "the doctor said I should have a special mattress, but I haven't got one."

On 2/6/25 at 2:00PM V2, Director of Nursing stated V2 is "the person responsible for wound care." V2 verified the wound Nurse Practitioner has recommended a low air loss mattress for (R2), and that the mattress was ordered. V2 did not offer an explanation as to why the pressure relieving boots were not in place. V2 verified that R2 should be checked and changed "at least every two hours and as needed or when requested" and that staff should never turn off a call light and fail to return.

The facility Resident Council Meeting Minutes dated 1/27/25 document complaints of call lights taking 30 minutes or longer to be answered. Residents voiced that the staff often answer the call lights, turn the light off, say they will be back, but then never return to meet the resident's need.

On 2/6/25 at 3:39PM V8 wound care Nurse Practitioner verified it would have been V8's expectation that incontinence care should be completed every two hours and as needed and moisture "is a contributing factor in (R2's) facility acquired pressure injuries and interferes with heeling." V8 stated (R2) "is right I was very concerned the facility did not report the area on (R2's) ischium until it was a Stage IV (pressure sore). Pressure caused the skin breakdowns and moisture contributed to the worsening." V8 further stated "I think the facility should provide training for the nurses and the DON in wound

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care. Also offloading (weight) off the wound is critical." V8 verified the pressure ulcers R2 is experiencing were avoidable. V8 also stated "maybe that area on (R2's) ischium did start out as a moisture associated skin deterioration, but by the time I saw it was definitely a Stage IV pressure ulcer."

R2's Wound Evaluation and Management Summary dated 2/12/25 documents Unstageable Pressure wound to right heel 2.8 x 2.6 cm, Unstageable Pressure wound to left heel 3.9 x 4.0 cm, Stage IV Pressure Ulcer to right Ischium 7.0 x 5.0 x 3.0 cm.

On 2/19/25 at 9:30AM R2 was not wearing boots as recommended by Wound Nurse Practitioner. R2 stated the boots were in her drawer. R2, who is cognitively intact per most recent MDS, stated she had become incontinent of bowel while standing in therapy at around 4:00PM yesterday. R2 stated Therapy Staff brought R2 back to her room and put on the call light. R2 states a CNA came to R2's room and turned off the call light but did not clean R2. R2 stated R2 put the call light back on at 4:30 PM and the same CNA came in and turned off the call light and stated they were busy and would clean R2 up as soon as they could. R2 stated it was 7:00PM by the time R2 was cleaned up.

On 2/19/25 at 9:10AM V12 CNA stated she was familiar with the care needed for R2 as V12 "takes care of (R2) most days." V12 stated V12 was not aware R2 needs to wear the boots. V12 also stated "I believe what (R2) says is accurate."

On 2/19/25 at 9:10AM V13, LPN verified R2 told V13 this morning (R2) was left without being cleaned yesterday from 3PM to 7PM, V13 stated

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S9999	Continued From page 9 "I don't know why (R2) would say that if it didn't happen." On 2/19/25 at 12:30PM V18 Dietary Manager verified R2 had not been seen by the dietitian for (R2's) Pressure ulcers. On 2/19/25 at 12:40PM V14, Corporate RN verified that it is the facility's expectation that all residents with new skin concerns be evaluated immediately by the dietitian. On 2/19/25 at 3:35 PM V8, Wound Care NP stated "if I had been aware of the wound on R2's Ischium sooner I could have made recommendations and evaluated and treated before the wound became so extensive. R2's ischium/Coccyx wound measured approximately four inches in diameter and three inches deep with malodorous yellow drainage muscle and bone were visible. Both heels had leathery black eschar approximately 2.5 inches in diameter. (B)	S9999		